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CONGRESSIONAL HEALTH POLICY EDUCATION PROGRAM

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Medicare Advantage 101

Congressional Health Policy Education Program

April 24, 2023

Agenda

1. Medicare Advantage – what is it?
2. MA's structure and financing
3. CMS oversight and regulation of MA
4. Discussion of recent policy developments
5. Audience Q&A

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MA: What is it?

- Medicare Advantage (MA) plans are **privately-administered** health insurance plans paid by the federal government to provide Medicare benefits.
- MA plans receive monthly **capitated payments** (set amount per enrollee) to provide covered services regardless of how much the beneficiary uses.

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Historical Overview

- Early models date back to the 1972 Social Security Amendments and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which encouraged enrollment in Health Maintenance Organizations (HMOs).
- Early restrictions and regulations were onerous. By 1979 only one prepaid plan (managed care) existed in Medicare.
- TEFRA encouraged enrollment, it wasn't as aggressive as the Reagan administration wanted, and by 1994 only 5% of Medicare was enrolled in managed care through the HMO managed care program.

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Balanced Budget Act of 1997

- After attempts at Medicare reform failed in 1995, the Balanced Budget Act of 1997 (BBA) passed with broad bipartisan support and instituted Medicare + Choice (M+C), formally designating it as Part C.
- M+C opened Medicare up to a host of new private options besides HMOs.
- M+C, however, still had significant restrictions on plan flexibility. In response, plans cut services, and enrollment in MA began to drop – from 6.3 million in 1999 to 4.9 million in 2002.

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MMA of 2003

- In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) reimagined M+C as Medicare Advantage. MMA significantly increased payments to plans participating in MA.
- MMA created additional Part C plans, including regional PPO plans to cover rural areas and Special Needs Plans for dual-eligibles.
- With the implementation of Part D, MA plans were required to offer at least one plan that included the Medicare prescription drug benefit (MA-PD).
- In response to MedPAC recommendations, Medicare instituted a bidding process for plan payments in 2006.

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Eligibility

- MA allows those eligible for traditional Medicare (Parts A and B for hospital and medical coverage) to receive their health insurance benefits through a plan administered by a commercial insurer, rather than the government.
- You cannot have an MA Plan and a Medicare Supplemental Insurance plan (Medigap) at the same time. Beneficiaries not enrolled in MA-PD plans may get a Medicare Part D plan at the same time.

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MA Plan Types

- Health Maintenance Organizations (HMOs): Require enrollees to see in-network doctors or pay higher out-of-pocket costs and require referrals to see specialists.
- Preferred Payer Organizations (PPOs): Offer broader networks and do not require referrals.
- Private Fee-for-Service (PFFS) plans: Allow enrollees to see any Medicare-eligible provider.

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MA Plan Types (cont'd)

- MA prescription drug (MA-PD) plans: Offer Part D coverage.
- Special Needs Plans (SNPs): For Medicare-Medicaid dual beneficiaries (D-SNPs), enrollees who are institutionalized (I-SNPs), and enrollees with chronic health conditions (C-SNPs).
- Employer Group Waiver Plans (EGWPs): MA plans that employers or unions provide to their retirees.
- Medical Savings Account (MSA) plans: Plan deposits funds into an MSA annually, enrollees responsible for all costs before deductible, then plan covers 100%.

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Coverage

- MA plans must cover all services provided under Medicare Parts A and B (except hospice).
- Plans may offer a prescription drug benefit (MA-PD). This makes up 89% of all MA plans.
- Supplemental coverage, including vision, dental, and in-home support services that aren't offered in Original Medicare, may be offered under MA-Plans, but are not required.

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Benchmarks, Bids, and Rebates

- **Plans bid to offer Parts A and B coverage** to Medicare beneficiaries. This determines the Medicare payment they receive.
- The benchmark is a **bidding target** determined by county-level FFS spending. It is set at 4 quartiles– 95, 100, 107.5, and 115% of the projected FFS spending for that county for the year.
- CMS calculates benchmarks based on the costs of all FFS beneficiaries, even those without both Part A and B.

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Benchmarks, Bids, and Rebates

- If a plan's bid is *below* the local benchmark, the plan keeps the difference between the bid and benchmark as a **rebate**. The average bid is around 82-83% of the FFS benchmark. Plans are required to use the rebate to lower patient cost sharing, lower premiums, or provide supplemental benefits.
- Benchmarks also vary based on a plan's **star rating** in the **Quality Bonus Program** that measures the quality of care that plans provide. Plans with high star ratings receive bonuses in their benchmarks, and plans in certain counties with low FFS spending and high MA enrollment plans with high star rankings can receive **double bonuses**.

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Supplemental Benefits

- In 2022, 94% of plans offered vision and dental.
- Beginning in 2019, MA plans were allowed to offer newer benefits, including in-home support services, support for caregivers of enrollees, and food benefits (beginning in 2020).
- In 2022, 17% of plans offered in-home support services, 6% offered support for caregivers, 15% offered food and produce benefits, and 7% offered meals beyond a limited basis. In total, 34% of plans offer at least one of these supplemental benefits.

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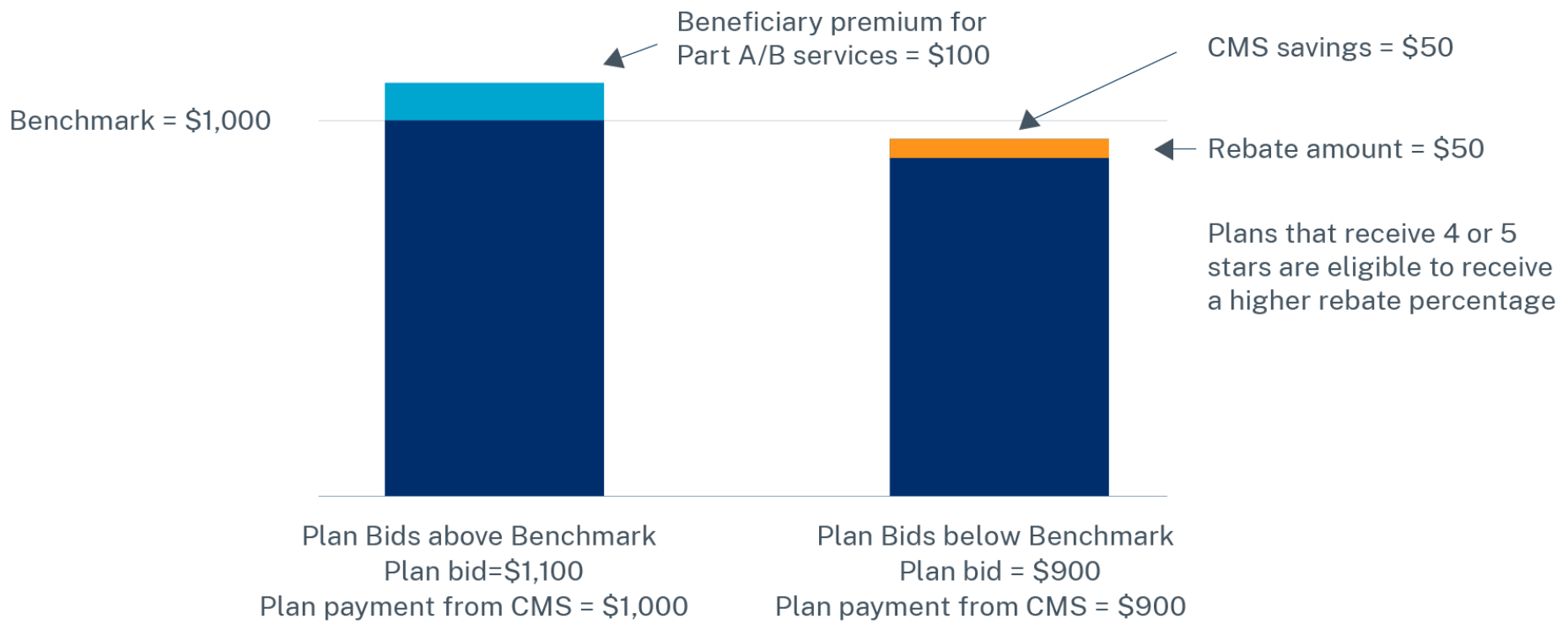
Benchmark Bid Example



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Star System and Quality Bonuses

- The quality ratings affect benchmarks and rebate size. The CMS star system is on a 5-star scale.

- Plans with 4+ stars receive a 5% **quality bonus**. Plans with high star ratings in **double bonus counties** receive 10%.
- **Low star ratings reduce the rebates plans receive**. Plans with 3 or fewer stars receive 50% of the difference between the bid and benchmark. Plans with 3.5 or 4 stars receive 65% of the difference. Plans with 4.5 or 5 stars receive 70% of the difference.

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Risk Adjustment

- Rebates and plan bids are **risk adjusted** to account for enrollees' health status and demographics (i.e., age, sex, dual status, or institutional status).
- Risk adjustment adjusts the capitated payment plans receive through **risk scores**. Insurers have incentive to collect data on medical diagnoses.
- To measure risk adjustment, MA includes the **hierarchical condition category (HCC)** coding to identify higher-risk patients and predict costs. HCCs are a set of medical codes that are linked to specific diagnoses
- Risk adjustment encourages plans to enroll sicker patients and avoid **adverse selection**.

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CMS Oversight & Regulation

- MA plans have more flexibility in administering benefits than traditional Medicare does
- CMS still retains a prominent role in enforcing standards and limits on MA plan activities
- CMS releases details on MA payment methodology for the following contract year in the Advance Notice/Rate Announcement, and proposes other changes through rulemaking from time to time

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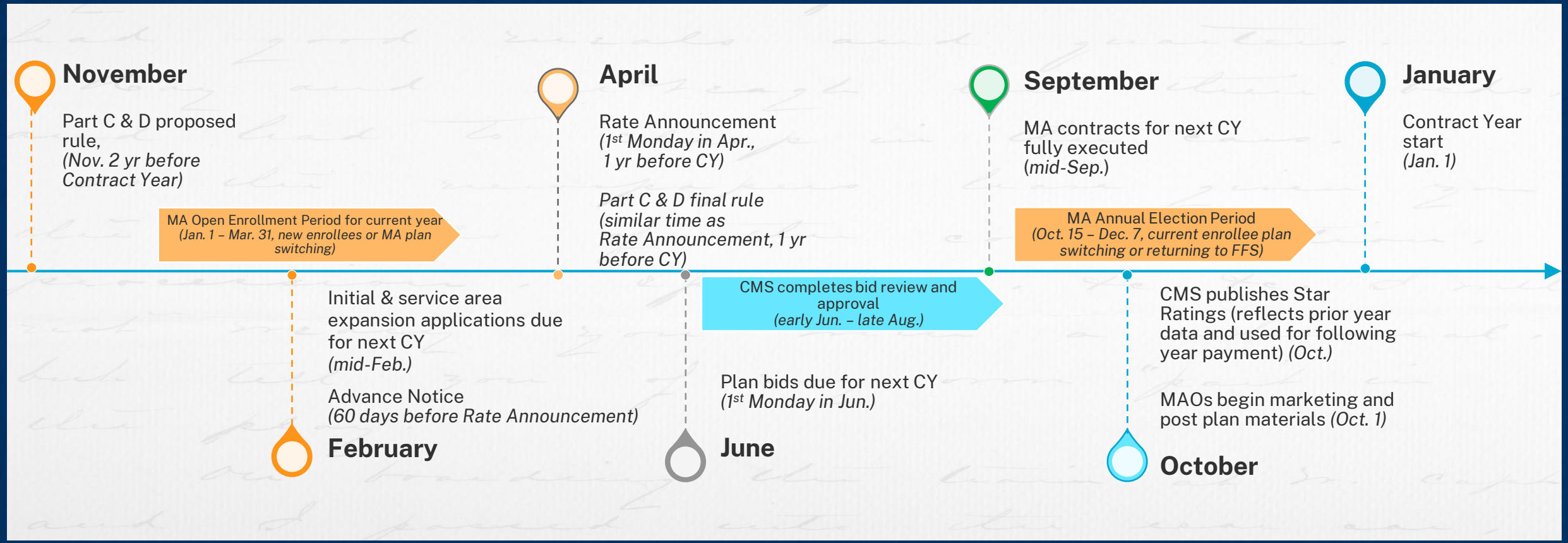
CMS Oversight & Regulation



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Benefits & Beneficiary Protections

- MA plans **must** cover:
  - Basic Parts A & B benefits (except hospice/trials)
  - All cost-sharing after maximum out-of-pocket cap
  - Uniform benefits to all enrollees in service area, regardless of health status/use
- Plans **may** offer:
  - Part D benefits
  - Different premiums/cost-sharing (uniform for enrollees)
  - Benefits not in Parts A/B/D (w/ rebates or extra premium)
- Non-discrimination/civil rights provisions apply

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Contract Requirements

- MA plans must:
  - Meet minimum enrollment requirements
  - Demonstrate administrative capabilities (e.g., personnel policymaking body, ethics policies, quality improvement program)
- MA plans may:
  - Enter contracts outside federal acquisition rules
  - Operate coordinated care plans
  - Cover multiple MA plans with a single contract
  - Have contracts terminated by CMS

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Relationships with Providers

- MA plans must:
  - Meet network adequacy requirements for area
  - Consult physicians on medical, quality assurance / improvement, and utilization management (UM) policies
  - Not restrict practitioners from providing advice
  - Not pay physicians to reduce/limit necessary services or place them at substantial financial risk (i.e., physician incentive plans)
- Recently added requirements:
  - Achieve behavioral health network adequacy (2024)
  - Establish a UM Committee (2024)

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Compliance with State Laws

- MA plans must be licensed as risk-bearing entities under state law
- Except for licensure/solvency rules (e.g., licensing for marketing reps), state laws on health plans do not apply to MA plans
- Federal law (including case law) preempts all other state laws

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Marketing Guidelines

- MA plans must:
  - Submit to CMS all marketing materials, including those used by third party marketing orgs (TPMOs)
  - Distinguish between “communications” and marketing activities
  - Only market during designated time periods
  - Document written scope of appointment before all marketing activities
- Recently added requirements:
  - Record marketing/enrollment calls by TPMOs (2024)
  - Space out educational and marketing events (2024)
  - Timing/content restrictions (e.g., superlatives) (2024)

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Beneficiary Grievances and Appeals

- MA plans must:
  - Establish procedures for determinations, appeals, and grievances, and provide to enrollees
  - Accept requests 24/7 and make timely decisions
  - Follow separate timing/process/notification rules for enrollee inquires, grievances, requests, and appeals
  - Assign relevant professionals to review (e.g., a physician must review determination requests)

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Other topics

- Utilization management (UM)
  - Plans may use UM rules, e.g., prior authorization, step-therapy for Part B drugs
  - CMS proposed UM restrictions, e-prior auth (2024)
- Medical-Loss Ratios (MLRs)
  - Plans must meet MLR of at least 85% ((claims + premium reductions + quality improvement + MSA deposits) / (total contract revenue) >= 0.85)
  - Otherwise, MAO must remit the difference between their MLR and the 85% threshold
  - CMS reinstated stricter MLR reporting requirements (2023)

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Recent Policy Developments

- CY 2024 Part C & D final rule (4/5/2023)
- 2024 Rate Announcement (3/31/2023)
- Risk Adjustment Data Validation (RADV) final rule (1/30/2023)
- Prior Authorization proposed rule (12/13/2022)

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Current MA Landscape

Year	Advance Notice*	Final Rate Announcement*	Change
2024	-2.27 *(+1.03%)*	-1.12% *(+3.32%)*	1.15% *(2.29%)***
2023	4.48% *(7.98%)*	5.00% *(8.50%)*	0.52%
2022	2.82% *(***)*	4.08% *(***)*	1.26%
2021	0.93% *(4.49%)*	1.66% *(5.22%)*	0.73%
2020	1.59% *(4.89%)*	2.53% *(5.83%)*	0.94%
2019	1.84% *(1.84%)*	3.40% *(3.40%)*	1.56%
2018	0.25% *(2.75%)*	0.45% *(2.95%)*	0.20%
Mean	**2.71%**	**3.85%**	**0.87%**

**(Parentheses include risk score trend); CMS only included trend in topline numbers for 2024, 2023, and 2018*
*** Risk score trend changed from Advance Notice to Rate Announcement*
****Risk score trend not available for this year*

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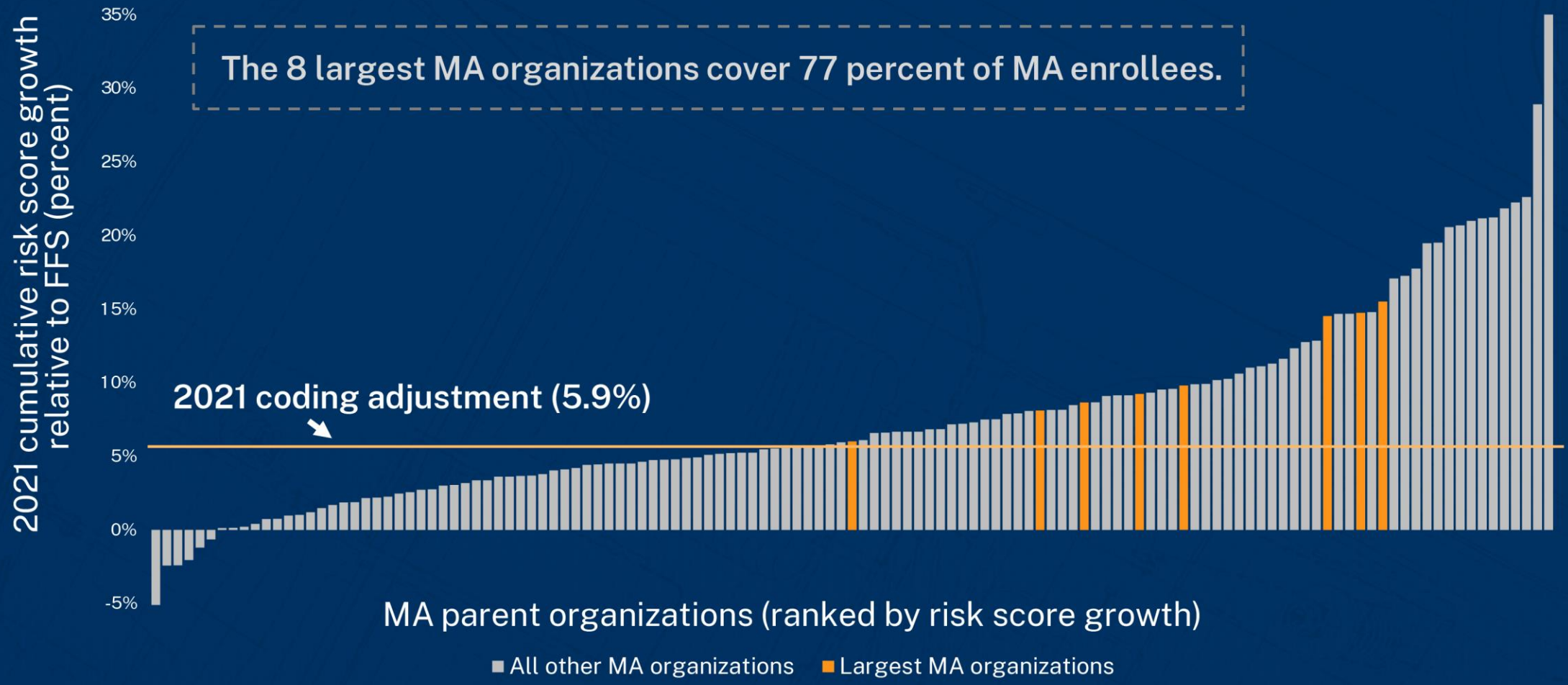
Coding intensity varies by 9 percentage points across the 8 largest MA organizations



Source: MedPAC

RADV Rulemaking

- **2018: CMS publishes proposed rule with:**
  - Proposal to recoup PY 2011-2013 overpayments using extrapolation methodology (found $650 million in improper payments from audits during these years)
  - Study finding FFS claims data does not lead to systematic MA payment error in MA and that it would be inequitable to only correct errors found in audits (i.e., no FFS Adjuster needed)
- **Final rule delayed after multiple extensions, subsequent study/data publications, and comment solicitations**

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RADV Rulemaking

2023 Final rule provisions:

- Codify use of any “statistically valid method” for extrapolation in RADV to collect overpayments
- Applying extrapolation to PY 2018 and later, not 2011
- Not applying an FFS Adjuster

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